

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the survey, the facility failed to ensure the resident's environment remained free of accident hazards as is possible. This was identified for one (Resident #1) of 20 residents reviewed. Specifically, Resident #1 was injured from their bed's installation hardware (bolt for a bed rail, which is an adjustable metal or rigid plastic bar that attach to the bed) that protruded beyond its frame. On 05/22/2026, Resident #1 sustained a cut to their right lower leg from the hardware on the bed while Registered Nurse #1 assisted the resident into bed. Resident #1 required hospitalization and 16 staples. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings include: The facility policy and procedure titled, Resident Safety and Accident Prevention, reviewed 01/2026, documented that the facility is committed to providing a safe and supportive environment for all residents by implementing a structured, proactive accident prevention program. It further documented that the facility routinely evaluates all resident-accessible areas for potential hazards and promptly implements corrective actions as necessary to reduce risk. All staff receive training on accident prevention strategies, resident-specific needs, and safe response protocols. The effectiveness of safety interventions is reviewed routinely and as needed following any incident, and adjustments are made accordingly. Resident #1 was admitted to the facility with diagnoses of myotonic muscular dystrophy (a genetic disorder that causes progressive muscle weakness and shrinking); peripheral vascular disease (a slow, progressive circulation disorder characterized by narrowing, blockage, or spasms in blood vessels outside the heart and brain); and Type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood). The Minimum Data Set (a resident assessment tool) dated 06/03/2026, documented that they could understand and be understood by others, and were cognitively intact. Record review of the facility's Investigative Report dated 06/01/2026 documented the following: On 05/22/2026, Resident #1 was lying in their bed when Registered Nurse #1 entered the room around 7:30 AM with medications and fluids. Upon assisting Resident #1 to a sitting position with their legs at bedside dangling over the edge, Resident #1 bumped their right calf on the side of the bed. Bleeding began to occur. Registered Nurse #1 assessed the wound and applied a dressing to the site. Due to the extent of the bleeding, the on-call medical doctor was notified. Resident #1 was sent to the hospital per the medical doctor's order regarding a laceration to the right posterior calf, where they received 16 staples to the site. Resident #1 also required a brief hospital stay for an unrelated diagnosis of aspiration pneumonia. Maintenance Director #1 was made aware of the incident and evaluated the mechanics and was able to safely remove the bolts. Upon meeting with the Interdisciplinary Team, it was determined that the best course of action would be to remove lower bolts from all facility beds to prevent further injury. Maintenance Director #1 reviewed the stability of the bed without the bolt and confirmed safety. They removed lower bolts from Resident #1's bed and as a precaution from all 119 other beds within the facility to prevent recurrence. The Hospital Discharge summary dated [DATE] documented Resident #1 had a significant history of diabetes and peripheral vascular disease; resident was recently admitted following a right leg laceration sustained (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	at a skilled nursing facility; staples were placed on 05/22/2026 by the emergency department. During an observation and interview on 06/12/2026 beginning at 1:30 PM, Resident #1 stated they had 16 staples in their leg. While a nurse transferred them, their leg was cut on the screw at the end of the bed. The bleeding was profuse, and the nurse called the doctor. They were sent to the hospital. Resident #1 stated they asked the nurse to take it easy, but the nurse was in a rush and abruptly moved them from the top of the bed to the bottom, causing their leg to be ripped by the screw on the bed. Resident #1 stated they did not think it was intentional and wished that Registered Nurse #1 had listened to them. There were bolts noted at the foot of Resident #1's bed. Resident #1 pointed to the bolt/screw and stated the bolt was what cut their leg. The resident was adamant that the bolt/screw was never removed. During an interview on 06/12/2026 at 1:50 PM, Maintenance Director #1 demonstrated on a vacant bed what the screw/bolt looks like when installed and is how it is delivered from the manufacturer. The screw/bolt was identical to what was currently in Resident #1's room. Maintenance Director #1 stated they were under the impression that their assistant had removed the bolts/screw. They stated Maintenance Assistant #1 is on medical leave at this time. During an interview on 06/12/2026 at 2:05 PM, Assistant Director of Nursing #1, Unit Manager #1, and Administrator #1 all stated they thought the bolts were removed. Assistant Director of Nursing #1 stated that Maintenance Assistant #1 brought them a box of screws. Assistant Director of Nursing #1 stated they did not go and check to ensure Resident #1's bed bolts were removed or ensure all of the facility bed bolts were removed as documented in the facility investigation. During an interview on 06/13/2026 at 12:20 PM, Registered Nurse #1 stated they were called to assess Resident #1 due to a change in condition and were attempting to hydrate Resident #1. Resident #1 was lying in bed in a semi upright position. They stated they assisted the resident to the edge of the bed in a seated position. They stated Resident #1 yelled out stop and pulled back; as the resident pulled back, the weight of their body pulled their lower extremities, catching onto the bed where there was a bolt. Registered Nurse #1 stated the dressing on the resident's right lower extremity had significant blood seeping through. They assessed, applied pressure dressing then notified the physician. The resident was sent to the hospital. During an observation on 06/13/2026 at 10:30 AM in facility rooms 210, 223, 224, 225, 227 and 228, there were bolts noted in the foot of the beds. During an interview on 06/13/2026 at 11:30 AM, Director of Maintenance #1 stated they were at the facility until 9:00 PM the previous night (06/12/2026), removing all the bolts from the lower portion of beds. They were unable to finish all of them and returned this morning to complete. They were in the process of finishing and must have missed a few. Maintenance Director #1 stated they had just completed removing all bolts from the lower portion of the beds in the entire facility. During an observation on 06/13/2026 at 11:40 AM, in facility rooms 210, 223, 224, 225, 227 and 228, the bed bolts were noted as removed. 10 New York Codes, Rules, and Regulations 415.12(h)(1)		